



## Budgeting and Fiscal Challenges in the 1990s

Lloyd K. Everson

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Part four in a series  
that explores the future  
of multidisciplinary  
delivery of cancer care

## Cancer Care Services

# Budgeting and Fiscal

by Lloyd K. Everson, M.D.

**F**inancial viability and stability are essential elements for any successful oncology practice and cancer program. Whether we are oncologists, nurses, radiation technologists, or administrators, understanding the current reimbursement systems in an evolving regulatory environment and effectively budgeting for cancer services are key challenges.

Moreover, in this era of health care reform, how an oncology practice positions itself for managed care is of critical long-term importance. Remember, it is not the federal government that is totally responsible for the changes in our health care system. It is the market forces that are causing the drop in the health care inflation rate and putting the pressure on providers of health care to deliver better quality care at a lower price.

### REIMBURSEMENT ISSUES

Over the past few years, health care and oncology in particular have witnessed the results of reform initiatives in different aspects of cancer services delivery. One of the most significant changes was the implementation of a new system of reimbursement for medical services: the Resource-Based Relative Value Scale (RBRVS). RBRVS, along with the change in coding for professional (E & M codes) and technical services and the Clinical Laboratory Improvement Act (CLIA) regulations, has profoundly affected the way cancer services are delivered.

Not only has the RBRVS affected Medicare payment structure, but it

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*Lloyd K. Everson, M.D., is  
President, American Oncology  
Resources, Inc., Houston, Texas.*

has also indirectly affected the non-governmental payor system in the United States. These approaches to service reimbursement could affect the types of patients treated and the site of where those services are delivered. (See "Cancer Program Development in the 1990's," *Oncology Issues*, Vol 2-4, 1993.)

A closer examination of how the E & M coding system is structured reveals the critical dependency of reimbursement on an increasing complexity of record documentation and site of service delivery. When comparing reimbursement for a specialist and a family practitioner, it can be argued that any specialty care, specifically medical and radiation oncology, requires a degree of medical sophistication and knowledge that should translate into a higher level of reimbursement.

The five levels of E & M coding require specific detailed information. Each encounter is coded in areas that include medical history, medical exam, medical decision making, and severity of the disease process. The American Medical Association's *CPT 1993: Physicians' Current Procedural Terminology* gives ample information on the requirements for each of the levels of service and indicates average time for these different levels of service. Any physician or administrator involved in an oncology practice can attest to the advantages and disadvantages of this coding approach.

From a patient and a physician's standpoint, ease of access and administration of services have been enhanced as we have moved from an inpatient to an outpatient setting of service delivery. The trend toward increasing outpatient management has accelerated. RBRVS has played its part in moving along that process even more rapidly.

Although the RBRVS system primarily influences the revenue side

# Challenges in the 1990s

of any budget process, it also plays a key role in understanding the costs associated with delivery. For example, in a capitated payor environment, the oncologist and business manager of a practice will be required to make a fairly sound estimate of costs for the average Stage II breast cancer patient. There should be a fairly accurate estimate of what the projected odds are that the patient and the practice will stay within those practice guidelines 90 percent of the time. A firmer handle on costs is the essence of the clinical and fiscal challenges in a managed care and capitated payor environment.

## LEGAL AND REGULATORY ISSUES

Federal agencies continue to scrutinize hospital and physician arrangements that are thought to violate the Medicare anti-kickback legislation and current "safe harbor" regulations of Health and Human Services. This is especially true in a non-profit, federally dependent organization.

In a state-of-the-art oncology practice or cancer program that attempts to provide integrated multidisciplinary focused comprehensive care, the requirements for funding to provide these services continues, despite constriction of net income available to fund those services and new technologies. Even recruiting new physicians becomes a difficult financial task in a constricting fiscal environment. Moreover, many other concerns are anxiety producing, including the necessity to acquire the business, management, computer data systems, expertise to track and analyze the practice, and service data for positioning in a managed care environment.

Notwithstanding the current discussions about Preferred Provider Organizations and Integrated

Health Care Delivery Systems, oncology practices and programs will naturally look to potential partners to group their resources to meet these challenges. Financial help from nonprofit hospitals may be in real jeopardy in this legal and regulatory milieu.

As alternatives, for-profit hospitals, commercial for-profit health care companies, multidisciplinary groups, and local specialty specific groups all offer the potential for grouping resources and meeting those integrated comprehensive service needs in a state-of-the-art practice. How well those business plans are implemented and how they are organizationally and legally structured to remain clear of any violation of the Medicare anti-kickback legislation will remain a key challenge for all of us concerned with cancer patient care.

## BUDGETING FOR CANCER SERVICES

Illustrated in Table 1 is an outline of a typical annual budget for a four-person medical oncology practice, including the line items of revenue, discounts, physician compensation, practice overhead, and net income. What is not readily apparent are the effects on this budget of health care reform and managed care.

*Gross revenue.* Gross revenue is dependent on the numbers of patients that are seen in a practice and the charges that are levied for the services provided. In the era of fee-for-service reimbursement, this was the key to driving the quest for market share in practice expansion and cancer program development. Said another way, in days past, "the more I do, the more I get paid." In an evolving environment of managed care or even capitation, gross revenue is no longer the key driver to profitability and service expansion

in a multidisciplinary cancer practice or program.

Under Option A (the fee-for-service model) in Table 1, the gross revenue line for this theoretical practice is six million dollars. Option B (the transition model) holds the gross revenue at the same level. Under Option C (successful managed care model) the gross revenue decreases by about 17 percent.

*Discounts.* Discounts are derived from the various contracts that a practice or cancer program negotiates with payors. Typically, this can amount to a third or more of the gross revenue charges. In a managed care or capitated market environment, not understanding the true costs of delivering oncology services can lead a practice to guess. In this situation, a pricing war can begin a dangerous spiral to program or practice unprofitability. Thus, if there is no added value to one practice approach, and the service price is only derived from finding the lowest price offer, then everyone, including the patient, loses. In the final analysis, diminished services are available to our patients, and the patient suffers from the lack of coordinated comprehensive cancer services.

In Option A, the discounts are indicated at a level of 35 percent. In Option B, the discounts have jumped to 50 percent of the gross revenues. In Option C, although the discounts have increased to 40 percent, this increase is in concert with real decreases in managed changes in the practice overhead.

*Physician compensation and practice overhead.* In Option A (the fee-for-service scenario) physician compensation enjoys a healthy percentage of the net revenue line. Indeed, under this hypothetical scenario there is income left over for distrib-

**TABLE 1. FOUR-PERSON MEDICAL ONCOLOGY PRACTICE**

	A		B		C	
	Fee-for-service model		Transition model		Successful managed care model	
Gross Revenue	\$6,000,000	100%	\$6,000,000	100%	\$5,000,000	100%
Discounts	2,100,000	35%	3,000,000	50%	2,000,000	40%
Net Revenue	3,900,000	100%	3,000,000	100%	3,000,000	100%
Physician Compensation	780,000	20%	390,000	13%	780,000	26%
Practice Overhead	2,925,000	75%	2,610,000	87%	2,000,000	67%
Net Income	195,000	5%	0	0%	220,000	7%

ution as bonuses, new services and technologies, or new physician recruiting. In Option B, however, where the discounts are increased by 15 percent and the overhead does not change, there is a dramatic drop in physician compensation. In this scenario, managing the practice overhead costs is a critical component to maintaining physician compensation, or for that matter allowing for any net income available for practice expansion, new services, clinical research, education, or new equipment acquisition.

Under Option C, the ideal successful oncology practice has adapted to the realities of the health care reform movement and is well positioned to competitively bid for payor contracts. Discounts are also increased as a percentage of gross revenues, since this practice has also had to discount more deeply to maintain many of its current contracts. Net revenues are also slightly down compared with the fee-for-service model illustrated in Option A.

The critical component to understand here is that the physician bears the ultimate clinical and financial risk. The question remains: Will the practice or physician also be in a position to enjoy the clinical and financial benefits?

Obviously, the key challenge in a managed competition environment with increasing discounts is to manage the cost side of the practice. This is certainly true in a capitated environment where an oncology practice may bid for hundreds of thousands of lives at a given rate for all, or at least the major part, of that population's anticipated cancer care. In this situation, the physician and cancer program move to the very

center of clinical and financial risk.

*Net income.* Net income may be defined in this theoretical model as that revenue left over to expand services, add new technologies, recruit new physicians, support clinical research and education, and add the essential business and systems management personnel and technology for the 1990s. Option A has money left over to do all the above. Option B does not. Option C, granted ideally successful, has the resources in the program or practice to do it all and continue in its vision of being a state-of-the-art cancer service.

**ONCOLOGY PRACTICES IN THE MANAGED CARE ENVIRONMENT**

Option C illustrates an ideal scenario for a practice successfully delivering health care in the managed care/capitated payor system. It serves to show the challenges that face all of us in this evolving health care environment. Gross revenues are down and the discounting rate is decreased, because the practice has negotiated a number of price and value sensitive contracts. Yet, in this illustration physician compensation is the same as in the fee-for-service model. In addition, there is net income available at the end of the year to use as bonuses, practice and service expansion. The practice overhead is also dramatically decreased.

These results are not done through some accounting magic. They are the result of improved management of the costs of the practice. Indeed, the oncologist of the future must deliver the majority of services in a more cost-efficient outpatient environment. Physician

extenders will be used to a degree unimagined even five years ago. Clinical pathway/care guidelines will be used increasingly to measure quality of care against the cost of care. Superior management and business systems have been put in place to deal with real cost accounting in this practice. In practices that optimize these approaches, costs will be held down and practice margins will be optimized. As one can plainly see, if this does not occur, physicians, cancer programs, or for that matter any healthcare program or services, will be out of business.

A parallel approach is emerging: the grouping of oncology practices and consortium cancer program development. These scenarios offer the potential of nonduplication of tertiary and specialized services and centralization of business management, information systems, and supply procurement. This approach offers the potential attractiveness of both economies of skill and scale. Coupled with clinical care guidelines, these are powerful tools to deal with the overhead expense challenge in all our practices and cancer programs.

In the final analysis there are only a limited number of approaches that can be used to maintain margins and develop enough net income for service expansion. These approaches are: market expansion, decreasing the discounting rate on charges, and controlling practice overhead. How we as physicians, nurses, and administrators in oncology practices and cancer programs adapt to these realities will eventually spell success or failure. ■